U.S. Department of Labor

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Issue date: 10Jul2002

In the Matter of	:	
	:	
JOHNNIE HERSHAL FRENCH,	:	
Claimant,	:	
	:	
vs.	:	Case No. 2000-BLA-394
	:	
WESTWOOD COAL COMPANY,	:	
SUE LEE COAL COMPANY, INC.,	:	
R.L. COAL COMPANY, INC.,	:	
Employers,	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS	:	
Party-in-Interest.	:	

Johnnie Hershal French,
Pro se Claimant

Russell Vern Presley, II, Esquire
For Sue Lee Coal Company, Inc., R.L. Coal Company, Inc., and Old Republic Insurance Company

BEFORE: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

Statement of the Case

This proceeding involves a first claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 et seq. (hereinafter "the Act") and regulations promulgated thereunder.[1] Because the Claimant was last employed in coal mine work in the state of Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (*en banc*). Since Claimant filed this application for benefits after January

[1] All applicable regulations which are cited are included in Title 20 of the Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are indicated as "D-", Claimant's Exhibits, "C-", Employer's Exhibits, "E-", and references to the Transcript of the Hearing, "Tr."

1, 1982, Part 718 applies. Since the claim was pending on the effective date, January 19, 2001, of the December 20, 2000 amendments to Parts 718 and 725, consideration of the claim is governed by the amendments in accordance with their terms.

The instant claim was filed by the Claimant, Johnnie Hershal French, on January 5, 1999 (D-1). On June 23, 1999, the Department of Labor awarded benefits (D-24, 25, 26,2 7). The named putative responsible operators, Westwood Coal Company ("Westwood"), Sue Lee Coal Company, Inc. ("Sue Lee"), and R.L. Coal Company, Inc. ("R.L.") were notified of the initial finding, and Sue Lee and R.L. filed timely controversions (D-29, 31, 32). By letter dated February 12, 1999, in response to notification of Westwood's potential liability, the Virginia Property and Casualty Insurance Guaranty Association (VPCIGA) notified the Department of Labor that Rockwood Insurance Company, Westwood's insurance carrier at the time of Claimant's alleged employment, was declared insolvent on August 26, 1991. VPCIGA further informed the Department of Labor that a one year time bar was set by the Court, and therefore, all claims would have to have been filed prior to August 27, 1992. Therefore, the VPCIGA would not appear in any further proceedings and would not indemnify in the event of an adverse decision in this claim. (D-20, 30, 39, 52). The remaining parties submitted additional evidence, and the District Director affirmed the prior award of benefits on October 6, 1999 (D-37). On October 15, 1999, Sue Lee and R.L. (the collective "Employer") requested a formal hearing (D-40, 41). Upon notification that due to Claimant's current earnings with East Tennessee Natural Gas, no Federal Black Lung Benefits were currently payable on his claim, Sue Lee and R.L. renewed their requests for a formal hearing on December 30, 1999 (D-45, 46, 47, 48). A hearing was held in Abingdon, Virginia on September 19, 2001, at which all parties were afforded a full opportunity to present evidence and argument.

ISSUES

1. Whether the Claimant has coal workers' pneumoconiosis?
2. Whether the pneumoconiosis arose out of coal mine employment?
3. Whether the Claimant is totally disabled?
4. Whether Claimant has proved that he is totally disabled due to pneumoconiosis?
5. Who is the properly designated responsible operator?
6. Whether the Claimant completed at least eleven years of coal mine employment as claimed?

FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

Background and Length of Coal Mine Employment

The Claimant, Johnnie Hershal French, was born on February 10, 1944, and has a high school education (D-1, Tr. 11, 28). Claimant married Madeline Smith on August 15, 1965, has remained married and was living with her at the time of the hearing. Therefore, Claimant has one dependent

for purposes of augmentation of benefits under the Act (Tr. 22-23; D-1, 7, 49).[2] Claimant is a lifelong non-smoker (Tr. 49).

Claimant alleges that he completed eleven years of coal mine employment (D-1). The District Director found that Claimant had established at least ten years of coal mine employment (D-10, 49). At the hearing, Claimant testified that he began working in the coal mines on February 19, 1976 for R.L., and that he worked for that employer until April 16, 1980, a total of approximately four years and two months. He also testified that he began working for Sue Lee on April 17, 1980. However, he could not remember when in 1985 he left. Nevertheless, Claimant testified that, upon leaving Sue Lee, he looked for employment for four to five months until he began working for Westwood on November 1, 1985. He worked for Westwood until July 12, 1986, for a total of approximately eight and one-half months. Assuming that Claimant spent four to five months looking for work upon leaving Sue Lee, Claimant worked for Sue Lee at least until June 1, 1985. Therefore, Claimant worked for Sue Lee for approximately five years and one and one-half months. (Tr. 35, 53, 60, 68). Based on Claimant's testimony, he completed at least ten years of coal mine employment. Claimant's Social Security records also indicate that Claimant completed at least ten years of coal mine employment, and, therefore, this tribunal finds that Claimant has established at least ten years of coal mine employment (D-5).

Claimant last worked in the coal mines for Westwood on July 12, 1986, when he was laid off (D-2; Tr. 34, 35, 38, 83). Claimant was employed by Westwood as a mine foreman, which required him to perform many different jobs including: monitoring the safety of the mine and equipment, extracting coal, running pinners, operating the shuttle car, checking for gas, scooping coal, rock dusting, and making sure everyone exited the mine safely (D-3, Tr. 35). Claimant's prior coal mine employment entailed work as a general laborer, rock duster, scoop operator, coal drill and cutting machine operator, and foreman (D-3; Tr. 29-32). Upon leaving the coal mines in 1986, Claimant worked as a carpenter for eight to ten months for Ranger Plant Construction (D-5; Tr. 50). Thereafter, in 1987, Claimant began working for East Tennessee Natural Gas as a mechanic and compressor operator (D-5; Tr. 42; E-10, 13). Claimant was still working for East Tennessee Natural Gas as a compressor operator at the time of the hearing, and testified that until a few months prior to the hearing, this job required considerable heavy labor. However, Claimant further testified that he received a promotion such that his job duties would no longer require excessive walking, lifting, and tugging. (Tr. 42-43).

The Responsible Operator

[2] At the hearing, Claimant testified that his son, Johnnie Hershal French II, who was born on January 16, 1979, was attending community college and that he and his wife pay Johnnie's tuition. Claimant did not know whether Johnnie was a full-time student, but testified that Johnnie works a at a full-time job in addition to attending classes. There is no documentation with regard to Johnnie's status as either a full or part-time student of record. (Tr. 24-27, 55-58). Accordingly, because §725.209 requires a nondisabled child who is eighteen years or older to be a full-time student in order to be a dependent for purposes of augmentation under the Act, the evidence does not establish that Johnnie Hershal French II is a second dependent of the Claimant.

Liability under the Act is assessed against the most recent operator which meets the requirements at §§725.494 and 725.495. The District Director designated three potentially liable responsible operators which met the prerequisites of §725.494 in this case: Westwood for whom the Claimant worked in 1985 and 1986; Sue Lee for whom the Claimant worked in 1980, 1981, 1982, 1983, 1984, and 1985; and R.L. for whom the Claimant worked in 1976, 1977, 1978, 1979, and 1980 (D-2; Tr. 35, 53, 60, 68). However, none of the three has been identified pursuant to the criteria set out in §725.495 as the actual responsible operator liable for payment of benefits in this particular case. Section 725.495(a)(1) provides that the operator or other employer with which the miner had the most recent cumulative employment of not less than one year shall be considered the responsible operator. As a result, where there is more than one operator for whom the claimant worked a cumulative total of at least one year, this section imposes liability on the most recent such employer. §725.495(a)(1).

The Claimant's most recent coal mine employer was Westwood. However, Claimant only worked for Westwood during a period of approximately eight and one-half months, and Westwood is not a viable responsible operator due to its insurance carrier's bankruptcy which precluded coverage (Tr. 16; D-20, 30, 39, 52). §§725.494(e); 725.495. Therefore, Westwood is not a potential liable operator. Pursuant to §725.495(a)(3), if the operator that most recently employed the miner may not be considered a potentially liable operator, as determined in accordance with §725.494, the responsible operator shall be the potentially liable operator that next most recently employed the miner. Sue Lee continuously employed the Miner for at least five years prior to his working for Westwood, and Sue Lee's insurance carrier, Old Republic Insurance Company, has accepted responsibility as Sue Lee's carrier in this claim (D-2, 5, 28; Tr. 53, 68). Accordingly, because Sue Lee meets the requirements of §§725.494 and 725.495, it is the properly designated responsible operator.

Findings of Fact - Medical Evidence[3]

Chest X-ray Evidence[4]

Exhibit No.	X-ray Date	Reading Date	Physician/ Qualifications	Interpretation
D-34	1/30/79	1/30/79	Navani B/R	0/0
D-34	7/28/84	7/28/84	Ramakrishnan R	0/0
D-13	3/3/99	3/3/99	Forehand B	1/0, q/q
D-14	3/3/99	3/30/99	Lippman B	0/1, s/t; poor inspiration could account for basilar changes
D-15	3/3/99	4/7/99	Navani B/R	0/1, q/p; bullae
D-34	3/4/99	3/4/99	Dahhan B	0/0
D-35	3/4/99	7/30/99	Wheeler B/R	0/0; bullae; ? TB
D-35	3/4/99	7/27/99	Scott B/R	0/0; bullous emphysema apices
C-1	3/4/99	6/9/00	Cappiello B/R	2/1, p/q; coalescence; COPD emphysema; bullae
C-2	3/4/99	5/26/00	Pathak B/R	1/2, p/q; emphysema; bullae; coalescence
C-3	3/4/99	6/12/00	Miller B/R	1/2, p/t; bullae; thickening of minor pleural fissure; coalescence
C-4	3/4/99	7/20/00	Robinette B	1/1, q/t; bullae; pleural thickening

[3]The professional credentials of Drs. Ramakrishnan, Alexander, Forehand, Joshi, Cole, Robinette, Haines and Coburn are not in evidence. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. This tribunal also takes judicial notice that Drs. Coburn and Alexander are listed as B-readers on the List of NIOSH Approved Readers. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.* , 14 B.L.R. 1-135 (1990).

[4] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis.

Exhibit No.	X-ray Date	Reading Date	Physician/ Qualifications	Interpretation
C-6[5]	3/4/99	9/16/00	Alexander B/R	1/1, p/q; coalescence
D-36	7/23/99	7/23/99	Dahhan B	0/0
D-42	7/23/99	9/29/99	Wheeler B/R	0/0; minimal bullous emphysema
D-42	7/23/99	9/28/99	Scott B/R	0/0; bullous emphysema apices
E-9[6]	2/01	--	--	1/1; mild interstitial pulmonary fibrosis with emphysematous change
E-13	8/10/01	8/27/01	Fino B	1/1; q/r

Pulmonary Function Studies[7]

Exhibit No	Test Date	Age/ Ht.[8]	Physician	Co-op./Undst./ Tracings	FEV_1	FVC	MVV	Qualify
D-8	3/3/99	55/ 67"	Forehand	good/good/yes	3.01	4.66	78	No

[5] Claimant submitted this x-ray interpretation at the hearing as part of a packet of supplemental exhibits. At the hearing, this tribunal determined that the entire packet was duplicative evidence and, therefore, did not admit its contents to the evidentiary record at that time (Tr. 64). However, upon review of the record, this tribunal now finds that this interpretation of the March 4, 1999 film by Dr. Alexander was not in evidence at the time of the hearing, and, therefore, is not duplicative, and should have been admitted into the evidentiary record. Upon consideration of the seven other interpretations of the March 4, 1999 film, this tribunal finds that Dr. Alexander's interpretation is consistent with the weight of the evidence, and is therefore not outcome determinative. Because Dr. Alexander's interpretation is merely cumulative, and there is no risk of prejudice because Employer has exercised its right to have the film reinterpreted, this tribunal has admitted that interpretation post-hearing to the record as Claimant's Exhibit 6.

[6] The evidentiary record does not contain an interpretation of this film in a discrete exhibit. However, Dr. Robinette described the film and its interpretation in his May 1, 2001 letter to Dr. Joshi (E-9).

[7] The second set of values indicate post-bronchodilator studies. Pursuant to §718.103 and Appendix B to Part 718, conforming pulmonary function studies require that the miner's level of cooperation and understanding of the procedures be recorded, and that the record of the studies include three tracings. To be qualifying, the FEV1 as well as the MVV or FVC values must equal or fall below the applicable table values found at Part 718, Appendices B and C.

[8] Because different heights have been recorded for Claimant, this tribunal must resolve the height discrepancy. *Protoppas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This tribunal averaged the recorded heights, disregarding Dr. Fino's recorded height of 69" as an outlier, and determined that Claimant is 67.06 inches tall.

Exhibit No	Test Date	Age/ Ht.	Physician	Co-op./Undst./ Tracings	FEV_1	FVC	MVV	Qualify
D-36	7/23/99	55/ 67.25"	Dahhan	fair/good/yes poor/good/yes	2.50 1.81	3.23. 3.10	36 42	No Yes
E-9	2/23/01	57/ 67"	Norton Community Hospital	--/--/no	3.14	3.88		No
E-7	5/2/01	57/ 67"	Robinette	good/good/yes	1.98 2.28	3.07 3.60		No No
E-13	8/10/01	57/ 69"	Fino	poor/good/yes	2.99 2.76	4.55 4.40	76	No No

Dr. Dahhan, board-certified in internal and pulmonary medicines, invalidated the July 23, 1999 pulmonary function study administered in conjunction with his examination of the Claimant due to the Claimant's poor effort (D-36). Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed and also invalidated the July 23, 1999 spirometry due to premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of abrupt onset to exhalation (E-1).

Arterial Blood Gas Studies[9]

Exhibit No.	Test Date	Physician	pO_2	pCO_2	Qualifying
D-11	3/3/99	Forehand	77 59	35 36	No Yes
D-36	7/23/99	Dahhan	89	35.3	No
E-13	8/10/01	Fino	87.3	35	No

Dr. Ranavaya, board-certified in occupational medicine, found the March 3, 1999 arterial blood gas study technically acceptable on March 25, 1999 (D-12).

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[9] The second line of the values shown indicates post-exercise studies.

CT Scan Evidence

Exhibit No.	CT Date/ Date Read	Physician/ Qualifications	Interpretation
E-5	2/21/01/ 2/21/01	Haines R	Emphysematous and bullous changes scattered throughout both lung fields. No parenchymal infiltrate is identified. Impression: COPD with chronic change as described. No definite acute radiographic abnormality was noted. No definite evidence of pulmonary embolus.
E-6	4/25/01/ 4/25/01	Coburn B/R	No definite interstitial fibrosis although there is some pleural scarring in the apices and evidence of bleb formation in the periphery with thickening of the peribronchial region.

Medical Reports/Opinions

A hospital report dated April 7, 1994, documents Claimant's examination by Dr. Cole, board-certified in otolaryngology. Dr. Cole diagnosed the Claimant with recurrent and chronic sinusitis. (E-8).

Claimant's Exhibit 5 contains treatment notes dated from February 4, 1999 through March 7, 2001, documenting Claimant's treatment by Dr. Joshi, board-certified in internal medicine and the subspecialty of cardiovascular disease. Dr. Joshi's notes indicate that Claimant has histories of cardiac arrhythmia, atrial fibrillation, sinus rhythm, and chest pain of undetermined etiology. When asked whether Claimant has coal workers' pneumoconiosis, Dr. Joshi replied that he was not sure and would require a chest x-ray to make that determination. Dr. Joshi was also unable to opine with regard to whether the Claimant retains the respiratory capacity to return to his former coal mine work. (See also E-3, 4). Employer's Exhibit 12 contains additional treatment notes dated from April 12, 2001 through June 12, 2001. The office note dated June 12, 2001 indicates that Claimant's current problems included: chest pain, atrial fibrillation now in sinus rhythm on anticoagulation, COPD/chronic bronchitis, and asthma bronchitis treated with Proventil inhaler and Advair.

Dr. Forehand, board-certified in pediatrics and allergy and immunology, examined the Claimant on March 3, 1999. (D-8, 9, 11). Dr. Forehand recorded a coal mine employment history of eleven years, lastly as a mine foreman. Claimant reported that he had never smoked and that his medical history only included surgeries for his eye and sinuses. Dr. Forehand's examination of the Claimant included a chest x-ray, pulmonary function and arterial blood gas studies, and an EKG. Dr. Forehand interpreted the x-ray as positive for pneumoconiosis. The pulmonary function study indicated a mild airflow limitation, and the arterial blood gas study indicated hypoxemia with exercise and no metabolic disturbance. Claimant's EKG produced a normal tracing. Dr. Forehand diagnosed coal workers' pneumoconiosis due to coal dust exposure based on the Claimant's history, chest x-ray and arterial blood gas testing. Dr. Forehand stated that a respiratory impairment of a gas-exchange nature is present which renders the Claimant unable to return to his last coal mining job and totally and permanently disabled. Dr. Forehand concluded that coal workers' pneumoconiosis is the "sole factor" contributing to the Claimant's respiratory impairment. Upon consideration of two

negative rereadings of the March 3, 1999 chest x-ray performed by Department of Labor B-readers, Dr. Forehand affirmed his prior diagnosis, reiterating his reliance on the data collected during his March 3, 1999 examination of the Claimant (D-10).

Dr. Dahhan, board-certified in internal and pulmonary medicines, examined the Claimant on July 23, 1999, and reviewed additional specified medical records for his July 29, 1999 report. (D-36). Dr. Dahhan recorded an eleven year coal mine employment history, lastly as a foreman. Dr. Dahhan noted that Claimant was currently working as an engine mechanic. Claimant reported that he was a nonsmoker and that his medical history was significant only for left eye surgery. Claimant's EKG showed regular sinus rhythm with normal tracings. His arterial blood gas study produced normal values at rest, and, while Dr. Dahhan noted that Claimant underwent an exercise study in which no desaturation took place, a post exercise blood sample could not be obtained. Dr. Dahhan invalidated Claimant's pre and post-bronchodilator pulmonary function studies due to poor effort, but noted that Claimant's lung volumes were normal and that his diffusion capacity was 70% of predicted. Dr. Dahhan interpreted Claimant's x-ray as negative for pneumoconiosis. Dr. Dahhan opined that there was insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis as demonstrated by the normal clinical examination of the chest, normal blood gases, normal lung volumes and diffusion capacity, and clear chest x-ray. Dr. Dahhan concluded that there were no objective findings to indicate any pulmonary impairment and/or disability based on the clinical and physiological parameters of his respiratory system. Dr. Dahhan noted Dr. Forehand's findings of a normal spirometry and normal clinical examination of the chest and arterial blood gases showing desaturation during exercise, and opined that Claimant's desaturation during exercise was not consistent with the other findings in addition to Claimant's normal lung volume and diffusion capacity measurements.

Dr. Dahhan concluded that, from a respiratory standpoint, Claimant retains the physiological capacity to continue his previous coal mining work or a job of comparable physical demands. He further concluded that, even if the Claimant were found to have radiological evidence of simple coal workers' pneumoconiosis, he would continue to conclude that from a functional respiratory standpoint, Claimant has no evidence of pulmonary disability. Dr. Dahhan ended his report by stating that, since the Claimant's entire respiratory exam showed no abnormality, he found no evidence of pulmonary impairment and/or disability in the Claimant's case caused by, contributed to, or aggravated by coal dust exposure or occupational pneumoconiosis.

Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his May 4, 2000 report. (E-1). In his brief discussion, Dr. Fino stated that he "saw no reason" why Claimant experienced a drop in pO_2 with exercise as noted by Dr. Dahhan, and that he did not believe that this was a valid blood gas study. Since Dr. Dahhan did not collect a post-exercise blood sample, and since Dr. Forehand's self-administered arterial blood gas study was the only other study reviewed by Dr. Fino, and that study indicated that Claimant experienced a drop in pO_2, it is evident that Dr. Fino was referring to Dr. Forehand's arterial blood gas study. Based on the information available, Dr. Fino concluded that there was no evidence of a coal mine dust-related pulmonary condition, and that there was no evidence of a respiratory impairment or pulmonary disability.

Dr. Fino examined the Claimant on August 10, 2001, and reviewed additional specified medical records for his report dated August 27, 2001. (E-13). Dr. Fino recorded an eleven year coal

mine employment history, lastly as a foreman, a position which involved heavy labor. Dr. Fino also noted that Claimant currently worked as a mechanic and operator at a natural gas station, a job which also requires heavy labor. Claimant's past medical history included asthma, bronchitis, frequent colds, emphysema, and sinus and heart problems. Dr. Fino interpreted the Claimant's x-ray as positive for pneumoconiosis. He noted that Claimant's spirometry was normal, stating that higher values would have been attained had the Claimant set forth better effort. Claimant's lung volumes were normal with air trapping present, and his diffusing capacity, oxygen saturation, carboxyhemoglobin level, and room air arterial blood gas were all normal. Based on review of the evidence before him and his interpretation of the Claimant's chest x-ray, Dr. Fino opined that the Claimant has simple coal workers' pneumoconiosis. Dr. Fino stated that the Claimant's pulmonary function study reports indicate that he has never set forth a maximum effort. Dr. Fino opined that the March 1999 arterial blood gases at rest and with exercise "do not square with the normal diffusing capacities and normal spirometric testing," noting that it would be unusual to have such a significant drop in pO_2 with exercise in the face of normal diffusing capacity values. From a functional standpoint, Dr. Fino opined that Claimant's pulmonary system is normal and that he retains the physiologic capacity from a respiratory standpoint to perform all of the duties of his last job, assuming it required sustained heavy labor. He opined that there is no ventilatory impairment because the normal spirometry shows no evidence of obstruction, restriction, or ventilatory impairment, and because the normal diffusing capacity rules out the presence of an impairment in oxygen transfer.

Employer's Exhibit 9 contains a letter dated May 1, 2001, from Dr. Robinette to Dr. Joshi documenting his recent evaluation of the Claimant's increasing shortness of breath and possible pulmonary venous hypertension. Dr. Robinette, board-certified in internal medicine and the subspecialty of pulmonary diseases, noted that an extensive cardiac work up confirmed evidence of cardiomegaly with recurrent atrial fibrillation. He also noted that Claimant is a nonsmoker and currently works as a compressor operator for the East Tennessee Natural Gas Company, a job which requires him to walk substantial distances up hill and on inclines. Dr. Robinette also recorded an eleven year coal mine employment history. Though not of record in this claim, Dr. Robinette described the results of pulmonary function testing performed at Norton Community Hospital on February 23, 2001. Those results are included in the chart above. Dr. Robinette also explained that a chest x-ray dated February 2001 demonstrated evidence of mild interstitial pulmonary fibrosis with emphysematous change, generalized cardiomegaly, and interstitial pneumoconiosis. That chest x-ray interpretation is not otherwise of record. Dr. Robinette diagnosed dyspnea upon exertion with a multifactorial etiology and a history of cardiac arrhythmia requiring chronic anticoagulation therapy. Dr. Robinette stated that he believed that the Claimant had evidence of intrinsic lung disease, and, that, therefore, he requested a CT scan and repeat pulmonary function studies.

Upon completion of the aforementioned studies, Claimant returned to Dr. Robinette's office on May 2, 2001 for further evaluation (E-10). Dr. Robinette noted that the CT scan failed to show evidence of interstitial fibrosis, but that there was some evidence of bleb formation in the peripheral aspects and some thickening in the peribronchial region compatible with an underlying diagnosis of asthma.[10] Claimant's pulmonary function studies, which are included in the record, suggested evidence of a mild to moderate obstructive pulmonary condition with reversibility suggesting some components of underlying asthma as an intrinsic diagnosis. Dr. Robinette explained that there was no evidence of significant interstitial pulmonary fibrosis or pneumoconiosis based on the high

resolution CT scan, and that another CT scan, which Dr. Robinette did not identify by date, showed evidence of more emphysematous changes and peribronchial thickening. Dr. Robinette stated that these findings probably accounted for the radiographic abnormalities he interpreted at the time of his initial evaluation. He also speculated that, "Certainly, one can possibly correlate the history of dust exposure with possible evolution of the radiographic findings as described." However, he did not opine such correlation was appropriate in this case. Dr. Robinette concluded that the Claimant has some components of reversible airways disease and suggested treatment with Adair and Albuterol. Dr. Robinette stated that he "allowed" Claimant to return to work on May 7, 2001, and prepared a prescription to that effect (E-11).

Conclusions of Law and Discussion

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

Existence of Pneumoconiosis

For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising from coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis. See §718.201. Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§718.304, 718.305, and 718.306; or (4) the finding by a physician of pneumoconiosis as defined in §718.201 which is based upon objective evidence and a reasoned medical opinion. Since the record contains no evidence of a biopsy or autopsy,

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[10] The CT scan to which Dr. Robinette referred is apparently the CT scan performed on April 25, 2001 and interpreted by Dr. Coburn. Dr. Coburn's interpretation indicates that the CT scan was ordered by Dr. Robinette, and Dr. Coburn's findings are consistent with those discussed by Dr. Robinette. (E-6).

the existence of pneumoconiosis cannot be established under section 718.202(a)(2). Since there is no evidence that Claimant suffers from complicated pneumoconiosis, the presumption set forth in section 718.304 is inapplicable. Since the claim was filed after January 1, 1982, and since this is not a survivor's claim, the presumptions set forth in sections 718.305 and 718.306 are inapplicable as well.

The existence of pneumoconiosis requires consideration of "all relevant evidence" under §718.202(a), as specified in the Act. Thus, if a record contains relevant x-ray interpretations, biopsy reports, and physicians' opinions, the Act would prohibit a determination based on x-ray alone, or without evaluation of physicians's opinions that the miner suffered from "legal," as opposed to traditionally clinical, pneumoconiosis. *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 B.L.R. 2-104 (3d Cir. 1997); *Island Creek Coal Co. v. Compton,* 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000).

The record contains seventeen interpretations of six chest x-rays. The two films taken prior to 1999, in 1979 and 1984, were interpreted as negative for pneumoconiosis (D-34). The March 3, 1999 film was interpreted as positive for pneumoconiosis by a B-reader, but also interpreted as negative for pneumoconiosis by a B-reader and a dually qualified board-certified radiologist and B-reader (D-13, 14, 15). However the March 4, 1999 film was predominantly interpreted as positive for pneumoconiosis: four dually qualified board-certified radiologists and B-readers and one B-reader interpreted the film as positive, while two dually qualified board-certified radiologists and B-readers and one B-reader interpreted the film as negative (D-35; C-1, 2, 3, 4, 6). The next film, taken on July 23, 1999, was unanimously interpreted as negative for pneumoconiosis by same three physicians who interpreted the March 4, 1999 film as negative for pneumoconiosis (D-36, 42). The most recent chest x-ray of record, dated August 10, 2001, was interpreted as positive for pneumoconiosis by a B-reader (E-13). Accordingly, of the seven dually qualified physicians who interpreted films in this case, four interpreted the films as positive, while three interpreted films as negative. The B-readers were divided two and two with regard to whether the chest x-rays evidenced the presence of pneumoconiosis. Because the preponderance of the dually qualified physicians agreed that the chest x-rays evidence the presence of pneumoconiosis, and their findings are corroborated by two B-readers, and because the B-reader's positive reading of the most recent x-ray is not contradicted, this tribunal finds that the radiographic evidence establishes that the Claimant has pneumoconiosis under §718.202(a)(1) by a slight preponderance.

Despite this tribunal's findings with regard to the radiographic evidence under §718.202(a)(1), evidence in the form of CT scan interpretations and reasoned medical opinions indicate that the abnormalities seen on x-ray are not attributable to pneumoconiosis or the Claimant's former coal mine employment. The two CT scans of record, both taken in 2001, were interpreted as negative for pneumoconiosis by two board-certified radiologists. However, both identified the presence of emphysematous changes and bullous or bleb formation, findings also noted by six of the seven dually qualified board-certified radiologists and B-readers who interpreted Claimant's chest x-rays (D-15, 35, 42; C-1, 2, 3; E-5, 6). Dr. Robinette, who is a pulmonary specialist and treats the Claimant for his respiratory condition, reconsidered his initial diagnosis of pneumoconiosis, which was based on the x-ray evidence, upon consideration of the CT scan evidence and pulmonary

function studies (D-44; E-9, 10). Dr. Robinette then concluded that the CT scans and pulmonary function test results were compatible with an underlying diagnosis of asthma (E-11). Although Dr. Robinette opined that the abnormalities he had previously determined from his own x-ray interpretation to be pneumoconiosis were probably the recently identified emphysematous changes and peribronchial thickening, he did not entirely discount the possibility that such changes were related to the Claimant's dust exposure history. However, Dr. Robinette stated that such correlation between the Claimant's dust exposure history and CT scan and radiographic changes was "only possible," and explicitly retracted his former diagnosis of pneumoconiosis, substituting for it a diagnosis of reversible airways disease (asthma). Because of his reasoning and the documentation, the second opinion is persuasive.

Pursuant to §718.104(d), this tribunal is required to give consideration to the relationship between a miner and any treating physician whose report is admitted into the record. Section 718.104(d)(5) further provides that, in appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to that opinion also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence, and the record as a whole. At the hearing, Claimant testified that Dr. Robinette is his "lung doctor," whom he had recently seen three times over a period of five months, and was currently scheduled to see for regular follow-up (Tr. 44-46). Based on Claimant's testimony and the evidence of Dr. Robinette's treatment of the Claimant, this tribunal finds that Dr. Robinette is Claimant's treating physician under §718.104(d). Moreover, because Dr. Robinette's opinion is well-reasoned, documented, and consistent with the objective medical evidence as a whole, and corroborated by the well-reasoned opinion of Dr. Dahhan, another pulmonary specialist, this tribunal accords Dr. Robinette's opinion controlling weight. (D-36).

Drs. Forehand and Fino both diagnosed the Claimant with pneumoconiosis. Dr. Forehand, who is board-certified in pediatrics, allergy, and immunology, based his diagnosis on his interpretation of the Claimant's March 3, 1999 x-ray, the Claimant's coal mine employment history, and the Claimant's arterial blood gas study indicative of exercise induced hypoxemia (D-9). Though well-reasoned in light of the objective evidence before him, Dr. Forehand's opinion is entitled to less weight than Dr. Robinette's because he is not a pulmonary specialist, the objective evidence of record militates against a finding of clinical pneumoconiosis based solely on radiographic evidence, and the arterial blood gas study upon which Dr. Forehand relied has been determined by two pulmonary specialists to be inconsistent and irreconcilable with the entirety of the objective evidence of record (D-36, E-1, 13). Dr. Fino's conclusory opinion that Claimant has pneumoconiosis was essentially unexplained, since it referred only to his x-ray interpretation and without particularity to his evidentiary review. (D-13). Because his opinion is undocumented, does not evidence or explain his consideration of the entirety of the objective medical evidence purportedly before him, and is inconsistent with the objective evidence as a whole, Dr. Fino's opinion is unpersuasive.

Thus, upon review of the entirety of the medical evidence under §718.202(a) and pursuant to *Compton*, this tribunal finds that the preponderance of the evidence does not establish that the Claimant has pneumoconiosis. While the radiographic evidence under §718.202(a)(1) could have established the existence of pneumoconiosis in the absence of contrary evidence, the more persuasive evidence of CT scans and the opinion of the Claimant's treating pulmonary physician, corroborated by the reasoned and documented opinion Dr. Dahhan, establish that Claimant's radiographic

abnormalities are not unequivocally related to his former coal mine employment. No physician opined that Claimant has a legal form pneumoconiosis. Thus, this tribunal finds that the most persuasive evidence contraindicates a finding of pneumoconiosis.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established at least ten years of coal mine employment. Thus,had he established the existence of pneumoconiosis, he would have also been entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment under the provisions of §718.203(b). But, because Claimant is held not to have established the existence of pneumoconiosis, the issue is moot.

Disability Due to Pneumoconiosis

To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlahem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

Under §718.204(b)(2)(i), all ventilatory studies of record, both pre-and post-bronchodilator , must be weighed. *See Strake v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). The record contains evidence of five pulmonary function studies. Because there are no tracings or other objective evidence of record related to the February 23, 2001 study, which produced non-qualifying results as reported by Dr. Robinette, this tribunal cannot determine its reliability, and finds that it is entitled to little weight. *Estes v. Director, OWCP*, 7 BLR 1-414 (1984). The July 23, 1999 study is also entitled to little weight because the two pulmonary specialists who reviewed the tracings invalidated the study due primarily to the Claimant's poor effort (D-36; E-1). The remaining three studies of record all produced non-qualifying results both pre and post-bronchodilator administration. Therefore, the entirety of the valid pulmonary function study evidence does not establish total disability pursuant to § 718.204(b)(2)(i).

Three arterial blood gas studies were performed between March 3, 1999 and August 10, 2001. The only study to produce qualifying results was the post-exercise study administered on March 3, 1999 (D-11). Drs. Dahhan and Fino reviewed this study in conjunction with the entirety of the medical evidence collected on the day of that study in addition to other specified medical

evidence, and opined that the test was inconsistent with Claimant's evidence of normal spirometry, normal clinical chest evaluation, and normal lung volumes and diffusing capacity (D-36; E-1, 13). Dr. Fino explicitly opined that the study was invalid (E-1). Because the preponderance of the arterial blood gas study evidence is non-qualifying, and because Drs. Dahhan and Fino provided well-reasoned opinions with regard to the invalidity of the only qualifying study's results, this tribunal finds that Claimant has not established total disability by a preponderance of the evidence pursuant to §718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has not proved total disability pursuant to Section 718.204(b)(2)(iii).

Finally, the medical opinions of the physicians who examined Claimant and reviewed additional medical evidence also fail to establish that the Claimant is totally disabled by a respiratory or pulmonary impairment. §718.204(b)(2)(iv). Only Dr. Forehand opined that the Claimant is totally and permanently disabled by a respiratory impairment, which he categorized as one of a "gas-exchange nature." (D-9). Dr. Forehand apparently based his finding of total disability on the post-exercise arterial blood gas study he administered to the Claimant during his March 3, 1999 examination. For the reasons discussed above, that arterial blood gas study cannot, in and of itself, support a finding of total respiratory disability. Therefore, Dr. Forehand's opinion regarding total disability is entitled to little weight. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc).

On the other hand, Drs. Dahhan, and Fino opined in well-reasoned and documented opinions that there were no objective findings to indicate that the Claimant had any pulmonary or respiratory impairment and/or disability, and that the Claimant retains the physiologic capacity to perform all the duties of his last coal mine employment as a foreman and his current job as a compressor operator and mechanic (D-36, E-1, 13). Because both physicians are pulmonary specialists, because both were able to examine the Claimant and review extensive medical evidence, and because their opinions are consistent with the entirely of the medical evidence and corroborative of one another, this tribunal accords their opinions substantial weight. While Dr. Robinette did not directly opine with regard to whether the Claimant is totally disabled by a respiratory or pulmonary impairment, his acknowledgment that Claimant last worked as a foreman and currently works in a position that requires him to walk substantial distances up hill and on inclines, coupled with his prescription for the Claimant to return to his position as a compressor operator on May 7, 2001, unequivocally indicates that Dr. Robinette did not find the Claimant totally disabled by a respiratory or pulmonary impairment (E-11). Accordingly, because the preponderance of the evidence under §718.204(b)(iv) indicates that the Claimant is not totally disabled by a pulmonary or respiratory impairment, and because the overwhelming preponderance of the objective evidence under §718.204(b) corroborates and is consistent with that evidence, Claimant has not established that he is totally disabled.

Total Disability Due to Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's

respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.* In this case, the preponderance of the evidence did not establish that Claimant has pneumoconiosis or that he is totally disabled. Therefore, the issue of whether the Claimant is totally disabled due to pneumoconiosis is moot.

Attorney's Fees

The award of an attorney'sfee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

ORDER

The claim of Johnnie Hershal French for black lung benefits under the Act is hereby denied.

A

EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.